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CHRONIC DISEASES

NOTES & REPORTS

CENTERS FOR DISEASE CONTROL ATLANTA, GEORGIA 30333 November 27, 1987

COMMENTARY

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The field of chronic disease prevention and control is one of the most dynamic and exciting in public health. Even in the few weeks since the first issue of *Chronic Diseases Notes and Reports* (*CDNR*) was published, much has occurred.

On September 16-18, over 550 people attended the Second National Conference on Chronic Disease Prevention and Control in San Antonio. Substantially more participants came from local health departments and voluntary health organizations than was the case at last year's conference, and we also had a contingent of health professionals from the People's Republic of China.

Participants during work session at Second National Conference on Chronic Disease Prevention and Control

The variety of participants and the different interests they expressed were in keeping with the special focus of this year's conference: Working Together — Players and Priorities. Sponsored jointly by CDC and the Association of State and Territorial Health Officials, this 2 1/2-day conference emphasized the diversity of groups working in the area of chronic disease and opportunities for collaborating to apply knowledge of how to prevent and control these diseases.

One major priority addressed during the conference was working together for minority and other underserved populations. In fact, an entire session and a series of working groups were devoted to discussing ways to serve these groups more effectively. Also featured were presentations on the perspectives of various "players"; workshops on specific diseases, risk factors, and interventions; and a session on model programs in Florida, West Virginia, and Nebraska for integrating national, state, and local chronic disease priorities. Summaries of work-group deliberations and the closing session are being edited and will be made available to those who attended the conference and to others on request.

It was at the Second National Conference that the first issue of *CDNR* was distributed. We want to thank all of you who have expressed your appreciation for this new special feature of the *MMWR*. It is gratifying to hear that this publication is useful, but we also want to know how to make it even more so. For *CDNR* to facilitate the timely exchange of the kinds of information on chronic disease prevention that you find valuable, your participation is essential. We hope that you will feel moved to pick up a pen or peck at a word processor and write a short description of your own program, a success or problem, or a request for others to share the same experience.

We are especially pleased to have a report in this issue from the American Heart Association (AHA) describing its activities in work-site health promotion called "Heart at Work." Voluntary health organizations, such as the AHA, play a major role in chronic disease prevention. Many examples were cited at the conference of collaborations between state and local health departments and voluntary organizations; e.g., the American Diabetes Association has worked with the Florida health department, and educational materials from the American Lung Association were used in a PATCH (Planned Approach to Community Health) project in West Virginia.

continued

Commentary continued

A particularly exciting development of the Conference is the plan of several directors of state chronic disease programs to petition the Association of State and Territorial Health Officials for affiliate status, joining the state epidemiologists, their colleagues in maternal and child health, and others. We applaud their zeal and look forward to interacting with them formally.

During the week of November 15-20, the second training course on chronic disease prevention and control was held in Atlanta, with 25 attendees from 24 states and the District of Columbia. This course incorporates improvements suggested by the participants in the first course held last June.

Even while tying up the loose ends of the Second National Conference, we have begun planning for the third. As soon as we know the theme, principal speakers, date, and place, we will share this information with you. As in the past 2 years, we are involving representatives from state and local health departments and voluntary organizations in planning for this third conference.

We hope that this special feature will serve as a means of communication among the "players" in chronic disease prevention and control and will help us maintain our enthusiasm and momentum. We also need to make the public aware of the critical importance of our work in chronic disease to their health and longevity. And through this to help people recognize that programs like the Great American Smokeout, Cholesterol Education Program, and mammography screening are central to chronic disease prevention and also critical components of public health and clinical prevention services.

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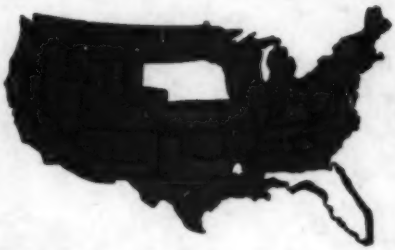

Florida CHIPs Away at Chronic Diseases

While debate continues in many areas about the possible benefits and deficits of integrating chronic disease programs, Florida is expanding a successful 2-year pilot program designed to ensure that patients receive comprehensive chronic disease care.

Under authority of a forward-looking state statute passed in 1986, Florida's Department of Health and Rehabilitative Services (HRS) developed Comprehensive Health Improvement Projects (CHIP). These ongoing projects in county public health units throughout the state enable patients to receive treatment for specific conditions, be examined for chronic diseases or associated risk factors, and be appropriately referred—all during one visit to a health-care facility. The CHIP program has been extended from the four counties participating in the pilot phase to include 11 new counties.

Dr. John J. Witte, Florida's Assistant Health Officer for Disease Control, said that CHIP was established to correct long-standing delivery problems created by funding and operating individual programs for diabetes, hypertension, cardiovascular disease, selected cancers, lung disorders, and arthritis.

"Before CHIP, an indigent client would come in to pick up insulin on Monday, be scheduled for a Pap smear on Wednesday, and be referred for nutritional assessment on Friday. Many persons served by the county public health units had chronic conditions or were at great risk for them and yet were unidentified and consequently unserved."

CHIP is beginning to change that. Today, clients entering county public health units that participate in CHIP, whether for family planning, prenatal care, treatment of a sexually transmitted disease, or another reason, are assessed for chronic disease risks and appropriately referred.

History of CHIP

HRS chronic disease personnel recognized the need for CHIP during chart audits at county public health units, according to Dr. Larry C. Deeb, consulting medical epidemiologist at HRS. "In 1984 and 1985, we noted serious gaps in the levels and patterns of care delivered to persons with diabetes. A closer look revealed similar gaps in other areas. In fact, even the headquarters chronic disease staff were making independent technical-assistance visits to counties and delivering training to health-care providers on a single disease."

After consensus-building workshops conducted by CDC, Dr. Witte's staff and consultants began the four-county pilot program. Each county worked within the CHIP framework and had the flexibility to establish its own goals. Data collection requirements for each county were minimal. Headquarters staff conducted chart audits to evaluate each site and the overall impact of CHIP.

Despite low funding and some turf guarding at various levels, the trial stage was an overwhelming success, according to HRS officials.

Benefits of CHIP

Measurable benefits of CHIP in the Florida counties include program networks, referral and tracking systems, improvement in county public health unit education capability, and extensive community health education programs.

"The networking achieved by the county public health units has been remarkable," Dr. Witte said. "Participation and support by voluntary health agencies continue to grow. Besides referring county public health unit clients to voluntary agency-operated education programs, the organizations are even donating supplies."

CHIP's comprehensive coverage has produced numerous situations of co-management of private patients. In one stop, a client may have blood pressure and blood glucose measurements, a Pap smear, an electrocardiogram, and breast and colorectal exams. Referrals based on the results are made to public-funded primary care clinics and to the private medical community. Referrals for nutrition assessment or counseling, diabetes classes, and smoking cessation education are made both to in-house and community-based organizations. Clients are scheduled for reexamination at frequencies prescribed by CHIP protocols, all of which are based on national consensus documents.

Another program benefit is in the area of health education. The education capability of the county public health units has improved, as measured by the increasing frequency of referral of private patients for teaching by health department staff. CHIP also has an extensive community health education component that stresses nonduplication of available programs. This component extends chronic disease learning opportunities beyond public health clients into the community. The goal is to increase communitywide knowledge about prevention and control of chronic diseases. The creativity of county public health units, analysis of data, and availability of resources determine the types of efforts chosen.

The Future of CHIP

"It is important to bear in mind that CHIP is a concept, not a new program," said Dr. Michael H. Wilder, State Epidemiologist. "The only CHIP staff is a coordinator who provides on-site assistance in linking programs, developing referral and tracking systems, and implementing a more extensive community health education program. After training, the coordinator becomes an in-service teacher for the public health unit staff in each county."

CHIP is viewed as a transitional mechanism. After 3 years of CHIP funding in each county, the monies (now $50,000 a year for each county) will be applied to new counties.

Funds are provided to offset transitional- and start-up costs. Counties are expected to complete the transition to program integration in 3 years and to continue operating within the CHIP guidelines. Planning for the new CHIP counties is being based on recently developed data packages that apply national chronic disease rates, with age adjustments, to each county's population.

According to Dr. Deeb, Florida's 12 diabetes projects are also using CHIP solutions. "We're seeing marvelous statistical improvements in the delivery and documentation of exams, care referrals, and client education," said Dr. Deeb. The basis for his observation is a medical-management flow sheet that both cues practitioners to the appropriate services for each client visit and also serves as a data-collection instrument. "The flow sheet has such valid medical implications that practitioners don't object to another form in the client record," stated Dr. Deeb.

A copy of the tear-off, self-carbon flow sheet is mailed to HRS headquarters for data entry and analysis using an automated software package, specially developed for CHIP and soon to be available to other states. The flow sheet provides clinic-aggregate profiles and a profile of individual client services over three visits without extensive chart review.

Dr. Witte offered high praise for both headquarters staff and county personnel involved in CHIP. "We are taking quite seriously our ability to reduce morbidity and mortality resulting from chronic diseases. This responsibility includes the total public, not just public health clients. We will shortly begin demonstrating CHIP's impact on the community as a whole," Dr. Witte promised.

Cigarettes Finance Nebraska Research Program

Most health professionals would be upset if funds for an important program were decreasing each year. However, this may not be true in Nebraska, where tax revenues that support the state's Cancer and Smoking Disease Research Program are slowly but surely declining each year.

In 1981, an act of the state legislature created this innovative program, which is funded by dedicated cigarette tax revenues. Under this act, Eppley Institute for Research in Cancer and Allied Diseases, a National Cancer Institute (NCI)-designated cancer center, receives $500,000 each year and the State Department of Health receives the rest. The latter portion is distributed in the form of grants to researchers at Creighton University and the University of Nebraska, the two universities in the state with medical schools. Since 1984 when the first tax revenue was actually recorded, the 1¢-per-pack cigarette tax has generated over $4.3 million for health department grants and approximately $2 million for the Eppley Institute. This means that the research program in Nebraska has been funded by the purchase of 12.7 billion cigarettes.

To date, 171 projects have been funded, including research efforts in such areas as human behavior, epidemiology, biochemistry, immunology, and pharmacology. Many projects have dealt with nutrition, a number with leukemia and lymphoma, and others with the effects of nicotine.

Every 2 years the health department works with the Eppley Institute to co-sponsor a Cancer and Smoking Disease Research Symposium. This gives national experts the opportunity to speak to Nebraska researchers, and Nebraskans a chance to share their research results with one another and the public.

An advisory committee composed of representatives from Creighton University and the University of Nebraska selects a technical review panel of scientists and physicians from outside the state to review all grant applications. For fiscal year 1988, 20 new grants and eight renewal grants were awarded.

Several additional benefits can be attributed to the Nebraska Cancer and Smoking Disease Research Program, according to Kathy Ward, Director of Chronic Disease and Disabilities for the Nebraska State Department of Health. One major benefit is the advantage the program gives Nebraska researchers competing for grants from other sources, such as the National Institutes of Health (NIH). "Our program gives researchers an opportunity to obtain preliminary data, which makes them much more competitive. Several NIH grants have been received in Nebraska as a result of this funding," she said.

"The program also serves as a good recruitment tool for both Creighton University and the University of Nebraska. Some very high caliber researchers have been attracted to the state because of the program," Ms. Ward added.

Recently, Nebraska was one of seven states awarded grants by NCI to study data-based interventions in cancer control. The Nebraska health department received the grant partly because of the work already being done in the Cancer and Smoking Disease Research Program. Ms. Ward says that data generated by the program will be used in the NCI-sponsored study. The grant went into effect on September 30, 1987.

Chronic Diseases Management Study Is Under Way

A major management study to analyze CDC's chronic disease control and prevention activities got under way in October and will continue for the next 3 months. A leading California management consulting firm, Pacific Consulting Group (PCG), was selected to conduct the study. PCG has the task of analyzing the past and current organization of CDC's chronic disease activities, assessing emerging program priorities, and providing top management with three feasible organizational options for chronic disease prevention and control activities at CDC.

CDC project officers for the study are Dr. Mary Guinan, Assistant Director for Science in the Office of the Director, and Ross Cox, a management analyst in the Office of Program Support. According to Cox, "The study takes a look at how CDC should be operating in the area of chronic diseases as opposed to how we are operating and proposes ways to function better in this area. We will have a lot of information about where CDC is going and how to get there. Opinions will be also solicited from state and local health departments."

PCG has begun the first round of interviews with top-level officials at CDC, and follow-up interviews will be conducted with staff involved in chronic disease programs throughout the organization.

CDNR plans to publish the study's findings.

"Nic-a-Teen" Discourages Teen Smoking

A new animated cartoon/public service announcement, entitled "Nic-a-teen," will soon make its debut with a message to young teens about the social turn-offs of cigarette smoking. The cartoon's hero, Nic—the last of the red hot Buttheads, is a lovable, bumbling cigarette smoker who encounters one social disaster after another as a consequence of his smoking.

For the second year, CDC's Office on Smoking and Health (OSH), Center for Health Promotion and Education, and state health departments have gone to the television

medium to urge children and young teenagers not to smoke. Last year, 42 states joined OSH in sponsoring a music-video public service announcement (PSA) that television stations and networks used widely across the country. The PSA, "Smoking's Out," told kids that smoking 'ain't cool.'

OSH conducts two concurrent public service advertising campaigns, one addressed to adults and the other to teenagers. The teenager campaign carries the single theme, **"you don't have to smoke,"** and over the years has been distributed with the co-sponsorship of many other agencies, including state and local health departments. PSAs have included "Star Wars," featuring film characters R2D2 and C3PO and recognized on the Johnny Carson show as an "advertising classic"; "Cigarette Mash," a CLIO-award winner; and "Smoking Kisses," voted by *Advertising Age* as the best PSA of 1986.

All OSH materials are pretested before they are released. "Nic-a-teen" was originally filmed as a scenario with an accompanying sound track to provide viewers with a first, rough idea of the commercial content and style. The test group contained equal numbers of boys and girls and of smokers and nonsmokers. The PSA tested extraordinarily high in communicated message, but less high in acceptance by the teenagers who smoked. As a result of the test, the script was modified to make "Nic" a more sympathetic person and to soften the defeats he encounters.

Many of OSH's advertising campaigns lend themselves to the creation of posters, and "Nic-a-teen" may eventually appear in print. A current OSH poster is a finalist in the National 1987 CEBA awards for excellence in communication to a black audience. The poster shows a young, black teenager working in a garage. Its caption reads, "You have enough smarts to rebuild an engine. And you're still smoking?"

For additional information, contact: The Office on Smoking and Health, Rockville, MD 20857; 301-443-5287.

Contributed by Robert Hutchins, Office of Smoking and Health, Center for Health Promotion and Education, CDC, Rockville, Maryland.

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States Study Behavioral Risk Factors

How many adults in Indiana smoke? What proportion of Minnesotans are sedentary? How many Californians are overweight? Since 1981, CDC and numerous participating state health departments have been able to answer these questions and more about personal habits that influence health. The mechanism that makes this information available is the behavioral risk factor surveillance system (BRFSS), a coordinated system of regular telephone surveys conducted by over 30 state health departments.

Today, it is clear why such information is important in the prevention of disease. However, even 50 years ago the concept of disease prevention, particularly the prevention of chronic disease, was ill-developed at best. Historically, the emphasis has been placed on treatment rather than prevention, since the causes of diseases were often unknown. Today, the causes of many diseases are well known and documented, and a primary responsibility of state health departments is to plan, implement, and evaluate disease prevention programs. But where does this process begin? Sometimes it begins with the answers to questions like those above.

When many factors act synergistically to cause disease, prevention strategies become more difficult to define. It is not enough to know what factors cause disease. Health policy makers must know the specific prevalence in their own state and community of the factors known to affect health adversely. The BRFSS provides these population-based prevalence data and enables health officials to implement more effective prevention programs.

Nine of the 10 leading causes of premature death in the United States can be linked to one or more of six behaviors: cigarette smoking, alcohol misuse, lack of exercise, failure to use seatbelts, overeating, and failure to control hypertension adequately. The BRFSS core questionnaire includes questions about personal habits regarding all of these behaviors. Typically, states participating in the BRFSS add questions of their choice to provide more detailed information on issues of special interest. The costs of the surveillance system are shared by CDC and the participating states.

Between 1981 and 1983, 29 states and the District of Columbia conducted one-time surveys. In 1984, the states began ongoing telephone surveillance by collecting data every month throughout the year. Currently, 35 states, comprising three-fourths of the adult U.S. population, are participating. To make information sharing more practical, CDC has developed a BRFSS teleconference among participating states using Dialcom.* Although just beginning, this communications link will make possible active discussions about the surveillance methods and practical use of the data for state programs.

The BRFSS data enable state and local health officials to custom design disease prevention efforts for individual communities. Because the BRFSS uses comparable methods from state to state and from year to year, a state can also compare

*Trade name is provided for identification purposes only and does not imply endorsement by any Federal agency.

its risk factor prevalence with prevalences of other states and monitor the effects of health prevention and promotion programs periodically. Also, because consistent methodology is used in a large group of states, geographic patterns of risk factor prevalence can be assessed.

Since the BRFSS began, techniques for data gathering have improved. In 1985, computer-assisted telephone interviewing techniques were instituted. Now, the telephone interviewer enters responses directly into a computer instead of manually recording them, thus providing edited data more quickly.

To maintain survey comparability from state to state over time, all states use the same core questionnaire, which has remained substantially unchanged. Nevertheless, because of increasing interest in preventive health practices, a new section was added to the questionnaire in 1987. The additional questions concern cholesterol and breast cancer screening practices in the states.

And now the answers to the questions in the first paragraph: the 1986 behavioral risk factor surveillance survey reports that 27.2% of adults in Indiana are current smokers, 54.6% of Minnesotans are sedentary, and 21.5% of Californians are overweight.

Contributed by Rebecca Hayden, Center for Health Promotion and Education, CDC.

Diabetes Translation Center Recommended by National Board

Researchers have developed effective methods and technologic advances that could help prevent chronic diseases and their complications, but often these proven strategies have not been fully incorporated into medical practice. As a result, many doctors are unaware of the advances, and patients are not helped as much as they could be. Now, a group of diabetes experts is acting to remedy this problem.

The National Diabetes Advisory Board (NDAB), mandated by Congress to plan the nation's fight against diabetes and make recommendations to the Secretary of Health and Human Services, has called for the formation of a diabetes translation center (DTC) at CDC. This center would "plan, conduct and coordinate national efforts to transfer diabetes research more rapidly to patient care."

NDAB recently published this and other major recommendations in the *National Long-Range Plan to Combat Diabetes, 1987* (published by the National Institutes of Health [NIH]). The recommendations designate CDC as the lead federal agency for translating diabetes research into practice. The new translation center would build on the successes of the existing Diabetes Control Program, which has been under way at CDC since 1977.

The model and responsibilities described for diabetes translation are the first such national recommendations. Dr. Alice Ring, Director of CDC's Division of Diabetes Control, said that "although the recommendations are specific for diabetes, the functions described in the plan for the DTC define activities and approaches traditionally carried out by CDC. They could also serve as a model for other chronic disease programs."

Diabetes Translation Center

The process of translation as described in the recommendations is complex, requiring a number of interrelated steps. These steps include the following:

- **Identifying effective strategies**
  The translation center, in cooperation with NIH scientists and other experts in the field, would identify prevention methods ready for use in clinical settings. Priorities would be established based on a number of factors: the *magnitude* of the problem in terms of morbidity, mortality, disability, and cost; the *potential impact* of the intervention on the problem; and the *feasibility* of the intervention in terms of cost, patient acceptability, and availability of resources to implement it.

- **Building Consensus**
  Many potentially valuable techniques have proved effective in carefully controlled clinical trials but have not been tested in community settings. Consensus would be reached on the strategies that should be tested in community demonstrations and, later, on those that effectively reduce morbidity and mortality in communities. The consensus process would not replace scientific research. It would, however, examine scientific findings, interpret them, and help public health agencies draw suitable conclusions and make the transition from research to community programs.

- **Conducting community studies and demonstrations**
  Working with state health departments and other appropriate groups, the DTC would implement community demonstration projects to test the effectiveness of these methods and technologies in community populations.

- **Helping implement and evaluate strategies**
  The DTC, in collaboration with state health agencies and others, would help implement on a wide scale those preventive efforts with proven effectiveness and evaluate their impact on morbidity.

- **Assisting with coordination**
  Effective chronic disease interventions require coordination at many levels. The center would work to assure that the recommended changes in patient and professional practices become an integral part of routine medical care. Professional and voluntary groups would also be encouraged to incorporate these principles into their recommendations and publications.

- **Providing technical assistance**
  The center would provide funds and technical assistance to states for identifying problems, conducting and evaluating programs, coordinating resources, and integrating programs into ongoing health-care-delivery, education, and financing systems.

- **Conducting research**
  DTC would conduct epidemiologic research and surveillance to identify evolving problems and develop solutions to program needs.

- **Developing methods of evaluation**
  Model outcome measures that form the backbone of the evaluation system would be developed.

- **Suggesting areas for research**
  The center would also identify research needs and refer these suggestions to the appropriate agencies and organizations.

Current CDC Diabetes Control Program

The existing Diabetes Control Program is already involved in some activities suggested by the National Diabetes Advisory Board. It provides state and territorial health agencies financial and technical assistance for carrying out community-based diabetes programs to prevent the complications of diabetes.

Four major complications are currently targeted for special attention: eye disease, amputations, adverse outcomes of pregnancies, and coexisting hypertension. These areas were selected because they cause significant morbidity and mortality that can be substantially reduced if known preventive strategies are widely practiced. For example, diabetes is the leading cause of new cases of adult blindness in the United States. However, clinical trials have shown that if diabetic retinopathy is found and treated with laser therapy before symptoms develop, approximately 60% of the cases of blindness due to diabetic retinopathy can be prevented. Community programs are currently screening high-risk persons for this eye condition and assuring follow-up and treatment. Preliminary results show that this effort has been very effective at the community level.

Community programs such as this are designed to be integrated into existing primary health care and financing systems and to increase patient access to and quality of care. At present, 29 states and one territory receive funds through cooperative agreements to carry out these programs. All 29 states are using strategies to prevent severe visual loss and reduce the adverse consequences of two of the other targeted complications. Because of limited resources, none of the programs are yet statewide.

Because diabetes and its complications disproportionately affect minorities and low-socioeconomic income groups, all participating states have targeted these groups for special emphasis. Most states are working with federally supported primary care programs, such as community and migrant health centers, maternal and child health programs, and family planning clinics. States are also linking diabetes programs with other chronic disease and risk reduction programs to use resources more effectively.

Participating states have succeeded in efforts to obtain third-party reimbursement for services such as diabetes outpatient education programs, considered integral to care. To date, 22 states have obtained coverage for outpatient education programs: 19 (66%) of the 29 that participate in the Diabetes Control Program and three (14%) of the 21 that do not participate.

Contributed by Division of Diabetes Control, Center for Prevention Services, CDC.

"Heart at Work" Works in the Workplace

The American Heart Association (AHA) has long taken the lead in educating the public about the risk of heart disease. Two years ago, AHA introduced a new national public health education program called "Heart at Work."

This program was designed to help employers motivate employees to reduce their risks of acquiring heart and blood vessel diseases—illnesses that kill almost 1 million Americans each year. Statistics show that approximately 15%-20% of all American employees have high blood pressure, 25%-35% smoke, 20%-25% are overweight, and only 10%-30% exercise at least three times a week. National health costs are approaching $500 billion annually, including lost salaries, rehiring, training, direct medical care costs, and insurance and disability claims. Heart and blood vessel diseases account for more than $85.2 billion of the total costs.

"Heart at Work," which involves AHA affiliates in all 50 states, is based on the application of "prevention technology" to prevent heart attack and stroke and to save lives. It adds new dimensions to the basic concept of health promotion, focusing specifically on the primary controllable factors that place millions of persons at high risk of developing cardiovascular disease.

The program represents a major effort to reach people where they spend much of their time—at work. "It creates a positive attitude among employees and shows them how to take charge of their own health," said Dr. Robert M. Daugherty, Jr., Dean of the School of Medicine at the University of Nevada at Reno. Dr. Daugherty, as chairman of AHA's national program committee at the time, directed the work of the volunteer committee that designed and tested this important educational program.

"Heart at Work" is a series of awareness and education activities that can be done on one of three levels. The first level helps employees become aware of the potential dangers of risk factors such as cigarette smoking and a high blood

cholesterol level. At the next level, high-blood-pressure screening programs, self-help smoking-cessation kits, lectures, slide-tape presentations, and informational literature are provided. The third level usually requires involvement by local health professionals for blood pressure monitoring or treatment, nutrition consultation, or cardiopulmonary resuscitation training. The flexible, modular program can be adopted in its entirety or in part by participating companies.

"Heart at Work" is relatively inexpensive because the programs can be done mainly with existing staff. Companies do not have to hire extra employees or outside consultants, and the program can be conducted at more than one location.

The educational program is designed to offer health promotion consistently over a long period. It also offers business and industry a program for building a supportive environment for employees. " 'Heart at Work' represents a wise investment in our most precious national resource, the working people of America," Dr. Daugherty said.

Information about "Heart at Work" can be obtained through local AHA offices.

Contributed by the American Heart Association, National Headquarters, Dallas, Texas.

New Health Center Is Tribute to Alabama Senator

The newly dedicated Lister Hill Center for Health Policy at the University of Alabama at Birmingham (UAB) honors the late Senator Lister Hill's commitment to improving the quality of the nation's health care system. The Center will function as a national center for the advancement of disease prevention and health promotion. It will work specifically to refocus national health policy on such goals as developing a proactive health care system, integrating treatment and prevention strategies, and reducing societally imposed threats to health.

The Center will support research and scholarship on prevention topics, and its activities will include a program of Lister Hill health fellows. These fellows, selected nationwide for their knowledge and accomplishments in the area of prevention, will receive financial support to serve as expert staff on key congressional committees.

The official dedication on October 5 marked the 40th anniversary of one of Senator Hill's most notable legislative achievements, the Hill-Burton Act. The passage of this act in 1947 provided federal assistance for building hospitals throughout the United States.

Participating in the ceremony were Dr. Charles A. McCallum, President of UAB; Dr. William F. Bridgers, Lister Hill Center Director and Dean of the School of Public Health; Howell Heflin, U.S. Senator from Alabama; and Dr. Paul J. Wiesner, Director of the Training and Laboratory Program Office, CDC.

The state of Alabama has contributed heavily to the formation and support of the School of Public Health at UAB, within which the Center will conduct its activities. In addition, Congress has provided a one-time $5 million endowment for the permanent operations of the Center.

Known on Capitol Hill as the "Statesman for Health," Senator Hill served over 45 years in Congress, 32 of them in the Senate. He was an advocate of disease prevention instead of treatment long before this was a popular idea, even among health workers. His contributions in the area of public health, biomedical research, and hospital care helped lay the foundation for the country's present system of health care.

Contributed by Carl H. Blank, Dr.P.H., Training and Laboratory Program Office, CDC.

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